Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Health Care North Dallas

Respondent Name
American Casualty Co of Reading

MFDR Tracking Number
M4-14-2600-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 22, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier's argument doesn't make any sense considering the information that was argued "not attached" including the g-code and documentation was attached…"

Amount in Dispute: $322.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Bill is denied correct. The provider has not submitted any medical records for this billed date of service to support payment, so the denial is being upheld."

Response Submitted by: Gallagher Bassett, 222 W. Las Colinas Blvd., Suite 250E, Irving, TX 75039

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 14, 2013 August 19, 2013 October 1, 2013	97002, GP 99213, 99080 99213	$322.62	$69.17

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for evaluation and management services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - 18 – Duplicate claim/service
   - 112 – Service not furnished directly to the patient and/or not documented

Issues

1. Did the requestor submit physical therapy service with appropriate modifiers and Function related G-code?

2. What is applicable rule that determines fee guideline?
3. Was the evaluation and management code supported for level of services billed?
4. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, 4 – "The procedure code is inconsistent with the modifier used or a required modifier is missing." 28 Texas Labor Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds the following;
    a. Medical bill for date of service August 14, 2013 contains 97002, GP with attachment of G8987, GP, CJ and G8988, GP, CI.
    b. CMS link, http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R165BP.pdf states in pertinent part, "Each reported functional G-code must also contain the following essential line of service information: • Functional severity modifier in the range CH – CN • Therapy modifier indicating the discipline of the POC – GP, GO or GN – for PT, OT, and SLP services, respectively • Date of the corresponding billable service

    Therefore, the Division finds the carrier's decision is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.
2. Procedure code 97002 represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.6 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.6054. The practice expense (PE) RVU of 0.61 multiplied by the PE GPCI of 1.017 is 0.62037. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.834 is 0.02502. The sum of 1.25079 is multiplied by the Division conversion factor of $55.30 for a MAR of $69.17. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $69.17.
3. The carrier denied the disputed services as, 112 – "Service not furnished directly to the patient and/or not documented." 28 Texas Labor Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99213 is:

    > Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; an expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

    The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

    - Documentation of the Expanded History
        - History of Present Illness (HPI) consists of one to three elements of the HPI. Documentation found listed one chronic condition, thus component not met.
        - Review of Systems (ROS) inquires about the system directly related to the problem(s) identified in the HPI. Documentation found listed one system. This component was met.
        - Past Family, and/or Social History (PFSH) are not applicable.
    - Documentation of a Expanded Examination:
        - Requires limited examination of the affected body area. The documentation found examination of one system: musculoskeletal. This component was not met.

    The Division finds the carrier's denial is supported. No additional payment can be recommended.
4. The total allowable reimbursement for the date of service August 14, 2013, in dispute is $69.17. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $69.17. This amount is

recommended. The dates of service, August 14, 2013 and August 19, 2013 were not supported by submitted documentation and no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $69.17.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $69.17 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		July , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.